Emergency Solutions Grant | 2015

Agency:_____ Staff Name:_____ County: _____ Date: ___/___/____

HOUSEHOLD MEMBER INTAKE FORM

Family Type: (Check One)
( ) Single/Unaccompanied Female ( ) Single/Unaccompanied Male ( ) Female w/ children ( ) Male w/ children
( ) Couple w/o children ( ) Couple w/ children

Last Name: _____ **First Name:** _____
Middle Initial: _____
Social Security Number: _____/_____/_____ **Pathways Client Key:** _____
Date of Birth: _____/____/_____ **Relationship to Head of Household:** _____
*If this is a minor, do you have legal custody/guardianship of him/her? ( ) Yes ( ) No ***[Provide Documentation]***

Sex: ( ) Male ( ) Female **Ethnicity:** ( ) Hispanic ( ) Non-Hispanic ( ) Transgender **Veteran:** ( ) Yes ( ) No

Race: ( ) Asian ( ) Black/African American ( ) American-Indian/Alaskan ( ) White ( ) Pacific Islander ( ) Other
Disabling Condition: ( ) Yes ( ) No **Chronically Homeless:** ( ) Yes ( ) No

Special Needs: Check ONE answer for each criterion

Substance abuse	( ) No		( ) Alcohol abuse	( ) Drug abuse
	( ) Both alcohol & drug abuse		( ) Don't know	( ) Refused
Long Duration?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Receiving/received treatment?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Physical disability	( ) No	( ) Yes	( ) Don't know	( ) Refused
Long Duration?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Receiving/received treatment?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Mental illness	( ) No	( ) Yes	( ) Don't know	( ) Refused
Long Duration?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Receiving/received treatment?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Illiterate or marginally literate	( ) No	( ) Yes	( ) Don't know	( ) Refused
HIV/AIDS and related diseases	( ) No	( ) Yes	( ) Don't know	( ) Refused
Long Duration?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Receiving/received treatment?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Domestic violence	( ) No	( ) Yes	( ) Don't know	( ) Refused
Experience occurred:	*( ) Within the past 3 months*		*( ) 3 to 6 months ago*	
	( ) 6 to 12 months ago		*( ) More than a year ago*	
	( ) Don't know		*( ) Refused*	
Developmental disability	( ) No	( ) Yes	( ) Don't know	( ) Refused
Long Duration?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Receiving/received treatment?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Chronic Health Condition	( ) No	( ) Yes	( ) Don't know	( ) Refused
Long Duration?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*
Receiving/received treatment?	*( ) No*	*( ) Yes*	*( ) Don't Know*	*( ) Refused*

Income and Non-Cash Benefits Information continued

Household Financial Resources: Receiving any non-cash benefits? ( ) No ( ) Yes ( ) Don't Know ( ) Refused

Non-Cash Benefits

	No/Yes	Date Started	Whose Benefit?
Supplemental Nutrition Assistance Program (SNAP)	( ) No ( ) Yes	____/____/____	_____
Special Supplemental Nutrition for Women, Infants and Children	( ) No ( ) Yes	____/____/____	_____
TANF Child Care Services	( ) No ( ) Yes	____/____/____	_____
TANF Transportation	( ) No ( ) Yes	____/____/____	_____
Other TANF funded services	( ) No ( ) Yes	____/____/____	_____
Section 8, public housing, or other ongoing rental assistance	( ) No ( ) Yes	____/____/____	_____
Other Source	( ) No ( ) Yes	____/____/____	_____
Temporary Rental Assistance	( ) No ( ) Yes	____/____/____	_____
Medicaid Health Insurance Program	( ) No ( ) Yes	____/____/____	_____
Medicare Health Insurance	( ) No ( ) Yes	____/____/____	_____
State Children's Health Insurance	( ) No ( ) Yes	____/____/____	_____
Veterans Administration (VA) Medical Services	( ) No ( ) Yes	____/____/____	_____
Employer Provided Health Insurance	( ) No ( ) Yes	____/____/____	_____
Health Insurance Obtained through COBRA	( ) No ( ) Yes	____/____/____	_____
Private Pay Health Insurance	( ) No ( ) Yes	____/____/____	_____
State Health Insurance for Adults	( ) No ( ) Yes	____/____/____	_____